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The intersection of sociocultural factors and health-related behavior: Experiences among young Black gay and bisexual males

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Abstract

Intersectionality is a theoretical framework that suggests that multiple social identities – e.g. race, ethnicity, gender, and sexual orientation – intersect at the individual or micro level of experience and reflects larger social-structural inequities experienced on the macro level. This article uses an intersectionality framework to describe how multiple stigmatized social identities can create unique challenges for Young Black gay and bisexual men (YBGBM) as an example. YBGBM exist at the intersection of multiple stigmatized identities compared to their majority peers. There is limited health-focused research on the intersecting identities of YBGBM. Using the lens of intersectionality to understand challenges to health-related behaviors and threats to health and well-being for YBGBM may reveal key opportunities for prevention and intervention for YBGBM and other gay and bisexual men from other ethnic groups. In this article, we examine the key intersecting identities (race, sexual identity, socioeconomic status, and cultural expectations (such as gender norms/masculinity, religious morality), that exist in YBGBM and how those factors may predispose young men to adverse health outcomes and health inequality.

Background

Intersectionality is a theoretical framework that suggests that multiple social identities – e.g. race, ethnicity, gender, and sexual orientation – intersect at the individual or micro level of

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experience and reflects larger social-structural inequities experienced on the macro level [5, 6]. This article uses an intersectionality framework to describe how multiple stigmatized social identities can create unique challenges for Young Black gay and bisexual men (YBGBM) as an example.

Adolescence is an important time of physical, social, emotional and cognitive growth and development in the life course[1]. The majority of sexual and gender minority (e.g., lesbian, gay, bisexual, transgender (LGBT) youth of color emerge from this period as healthy adults, having successfully achieved these developmental tasks [1]. However, relative to their majority peers, these youth face greater, formidable risks to their health and development [2]. Young Black gay and bisexual men (YBGBM), and other young Black men who have sex with men (YBMSM), in particular, carry one of the greatest public health burdens in the U.S., disproportionately accounting for over half (55%) of all new HIV infections in young men who have sex with men (YMSM)[4]. YBGBM experience multiple inequities compared to their majority peers by virtue of their membership in multiple oppressed and marginalized groups.

There is limited health-focused research on the intersecting identities of young Black gay, bisexual and other men who have sex with men [5, 7] but using the lens of intersectionality to understand the threats to health and well-being these young men face may provide key opportunities for prevention and intervention. In this article, we examine the key intersecting identities such as race, sexual identity, and cultural expectations (e.g. masculinity, and religious morality) (Figure 1), that exist in YBGBM and how such factors may predispose young men to adverse health outcomes and health inequality. We also describe socio-contextual promoting and protective factors that may further modify this relationship as well as clinical pearls that practitioners can use to help mitigate risk and negative outcomes in YBGBM. While this article predominantly focuses on HIV risk in YBGBM, many of the key concepts described in this article, such as intersectionality, can be applied to the lived experiences of all LGBT youth that occupy multiple identities.

Racial and Sexual identities

One of the key tasks of adolescence is identity development, [8] a stage where adolescents and emerging adults come to understand the specific ways in which they fit into society. This task involves developing one's self-concept which includes both personal identity or perception of self [8] and group identities – i.e. membership and identification with a group of people with shared characteristics salient to an individual's self-concept [9]. Racial or ethnic identity, for example, is a group identity based on common heritage and a common sense of identity, affecting one's internal self-concept and interactions with others [10]. Racial/ethnic identity is oftentimes more significant to the self-concept among ethnic minorities and racially oppressed groups [11]. Several theorists have argued that racial identity may be more salient for Blacks relative to Whites overall because of specific discrimination and racial prejudice Blacks have historically faced in the U.S. [12] and the shared struggle for equity and acceptance within the majority population [11, 12].

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Sexual identity development in YBGBM, involves two related processes: identity formation – awareness, questioning and exploration of sexuality – and identity integration – incorporation of sexuality into one's self-concept. Identity integration has been further conceptualized as involvement in lesbian-, gay-, or bisexual- (LGB) related social activities, resolving homo-negative attitudes, becoming comfortable with others knowing about a LGB sexual identity, and disclosing sexual identity to important others [13]. Identity formation and integration of developmental processes are often non-linear and variable across and within individuals. This variability is normal, but difficult or delayed identity integration has been associated with poor markers of psychosocial adjustment in youth including depression and anxiety, conduct problems, and poor self-esteem [13].

Disclosing sexual identity or "coming out" is not uniformly adaptive; rather the benefit of coming out depends on social context [14]. Norm compliance and collectivism rather than individualism and self-expression in racial/ethnic minority groups may be more important in the process of sexual identity development in sexual minorities of color than uniform disclosure seen in other groups [15]. For example, Legate et al (2011) found coming out was associated with higher self-esteem and less depression and anger in autonomy-supportive contexts (i.e. interpersonal support for authentic self-expression) but not in controlling social contexts (i.e. interpersonal pressure to conform to socio-behavioral norms) [14]. As such, affiliation with sexual minority communities and LGB-related social events has been described as less relevant for YBGBM [16].

Additionally, YBGBM may experience a conflict between same-sex sexuality and homo-negative (i.e., heterosexist, antigay) cultural expectations of masculinity and religious morality [17, 18]. Because of this conflict, some YBGBM may experience or fear that they will experience rejection, ridicule, and isolation from family, peers and community during key moments in adolescent development. For a group that often identifies first with their racial identity [19, 20], and draws strength and support from that community [21], preserving that connection may be paramount to "coming out" or otherwise embracing or assuming a gay/bisexual identity [22, 23]. Rather than risking that connection, an individual, whose dominant identity is his racial identity, may compartmentalize his sexual identity [23]. In this context, nondisclosure of sexuality may be protective and adaptive by allowing the individual to preserve important social supports [24]. However, as sexual and racial minority youth, the internal conflict some young men wage between cultural expectations and their sexuality may further isolate them at a time when interpersonal attachments are important [25], particularly if this conflict precludes them from accessing other, appropriate sources of social support related to their sexuality [26].

Cultural Norms/Expectations

Masculinity

Normative and dominant masculinity in American culture has been described as anti-feminine, homophobic, heterosexist, and misogynistic. [27] Some have suggested that stereotypical male gender roles of hyper-masculinity (i.e., exaggeration of traditional masculine roles through behaviors such as sexual prowess, physical dominance, aggression, competition, and anti-femininity) seen in some Black men may be a way for Black men

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disempowered by a social context of limited access to socioeconomic power, racism, and discrimination by a predominantly White male society to demonstrate power and authority [22, 28] and to approximate the American masculine ideal.

This compensatory expression of hyper-masculinity has been suggested as an important coping strategy for racism, oppression and marginalization particularly in young Black men. Majors' and Billson's [28] conceptual framework "Cool Pose," describes a hyper-masculine strategy embraced by Black males to cope with and survive in the face of social oppression and racism. Lacking the resources to obtain the traditional American societal prescription for masculinity, "Cool Pose" fosters the development of compulsive masculinity as an alternative to traditional definitions of manhood that "compensates for feelings of shame, powerlessness and frustration" by typifying toughness, sexual promiscuity, and violence to resolve personal conflicts [28].

The expression of hyper-masculinity among Black men has also been associated with community and peer acceptance as well as fortification of self-image and self-esteem [29]. In contrast to the expression of hyper-masculinity, disclosure of homosexuality has been associated with depressive distress, alienation and social isolation within Black communities [30]. These social sanctions are due, in part, to perceived direct contradictions between "hyper-masculine" gender role expectations for Black men and association of homosexuality with exaggerated stereotypes of being weak and effeminate [31, 32]. YBGBM may alter their presentation or expression of masculinity as a strategy to either avoid ridicule or to fit in and maintain social ties with important others [33, 34].

While maximizing social reward and avoiding social sanctions are strong motivators, achieving or striving for these homo-negative masculine expectations carries significant risk for young Black men who have sex with men (YBMSM). Fields, et al (2015) applied Gender Role Strain theory to a sample of YBMSM who felt pressured to conform to homo-negative expectations of masculinity from important others – e.g. family, peers and community. In this analysis they found examples of psychosocial distress, efforts to camouflage or hide same-sex behavior and identity, strategies to prove one's masculinity and the potential for increased HIV risk through social isolation, poor self-esteem, reduced access to HIV prevention messages, and limited parental involvement in sexuality development and exploration [33]. Moreover, the norm of nondisclosure of same-sex behavior in Black communities where homosexuality is viewed as incompatible with masculine expectations [18, 27, 33] can create opportunities for HIV risk for YBGBM, including exploration of sexuality in hidden, high risk, often age-discordant settings such as the internet and telephone-based venues.

Religion

Religiosity and religious affiliation has generally been associated with positive mental and physical health outcomes in both cross sectional and prospective studies [35, 36]. However among sexual minorities, the beneficial impact of religion is less clear. Religious affiliation, while protective in some ways, has also been associated with mental health pathology in YBGBM including psychological distress, depression, poor self-esteem, and internalized homophobia [37]. This relationship between religious affiliation and internalized

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homophobia has been described by minority stress theory which posits that health disparities affecting sexual minorities are the result of differential exposure to stigma, homophobia, and rejection [38] (see Ch. 5). As a result of this process, some LGB youth may disassociate more from institutional religion as a coping strategy to avoid the stressors associated with homo-negative and potentially stigmatizing social environments [39].

The salience of religiosity in Black communities may limit the value and relevance of disassociation as a coping strategy for YBGBM. The Black Church, a term that refers to the seven historically Black protestant denominations founded after the Free African Society of 1787 and representing over 80% of Black Christians in the U.S. [40], is a central religious, social and cultural institution in Black American society. It is uniformly recognized as the most influential institution in Black American society [40] and has been at the center of social and political activity throughout history, leading the Civil Rights movement, and other social justice issues related to racial oppression and discrimination [41]. The Black Church has also been a refuge from discrimination and marginalization for Black communities [41]. Upwards of 80% report religion as an important part of their lives, [42] and for many of these individuals religion and affiliation with the Black Church as a religious and socio-cultural institution are salient to both their self-concept and their Black identity [43], [44].

While Black churches are not a monolithic entity and do not uniformly object to homosexuality, many, like other religious institutions, do espouse proscriptive messages against same-sex behavior and identities [41]. The Black Church as an institution has generally been described as homophobic and intolerant of same-sex sexuality [41] and is one of the principal sources of homo-negative messages in Black communities, [32, 34, 41] influencing church goers and non-churchgoers alike. In some churches, this message is manifested as silence during the AIDS crisis [41] and in others, the message manifests as explicit and consistent condemnation of homosexuality and homosexual persons [31, 34]. This is sometimes replicated in families, among peers, and in the larger community. In addition to the morality of homosexuality, the conflation of gender and sexuality in masculine socialization described above is also entwined in the homo-negative messages, [32] which further emasculates such men by making them incapable of meeting expectations for men in the church or in the larger community [32, 45].

YBGBM are challenged with significant conflict at the intersection of their same-sex behavior and sexual identity, racial identity, and religiosity. For many the church environment is highly salient to other aspects of their multiple and intersecting identities and central to Black American life and Black racial identity [44]. In studies of YBGBM experiences with religiosity, many describe managing this conflict by compartmentalizing their sexual identity within religious contexts. Balaji et al (2012) in a qualitative study of 16 young (19-24) YBMSM, described study participants engaging in ‘role-flexing,’ a strategy for maintaining masculine expectations and camouflaging/concealing sexual orientation to avoid exposure to direct homo-negative prejudice in religious settings [34]. This strategy may place youth, particularly those who have not integrated their sexual identity into their sense of self (i.e. identity integration), at risk for internalizing many of the homo-negative messages they seek to avoid [31, 34]. Others, often older adults, described managing this conflict by integrating their religiosity and sexuality through attending religious (often non-

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Black or non-Christian) institutions that affirmed same-sex sexuality, creating new religious communities outside of traditional church environments, abandoning institutional religion in favor of a more personal, individual relationship with a higher power, or remaining in traditional Black religious institutions and rejecting homo-negative or non-affirming messages [48, 49].

Promoting Factors

In the preceding sections we provided a conceptual approach to understanding how intersecting identities like race, gender, and culture impact one's risk for adverse health outcomes. Marginalization for YBGBM can be further promoted by factors like poverty and low socioeconomic status, racial segregation, homo-negativity, stigma and limited social connectedness. YBGBM, for example, are often disproportionately burdened by the socioeconomic inequity and poor social and built environment that increases risk for HIV and other poor outcomes relative to their White sexual minority peers [58]. Table 1 reviews these promoting factors further and summarizes how these factors increase risk for HIV and other health and social disparities for YBGBM. Factors such as poverty, social environment (including racial segregation), homonegativity, stigma, and limited social connectedness can further isolate YBGBM predisposing them for risk. Such factors further perpetuate macro-level factors that impact on the individual level.

Protective Factors

Despite the prevalence of stigma, discrimination, and marginalization, most YBGBM are remarkably resilient, develop coping strategies, build social support networks, and have good mental health [87]. YBGBM often have access to several protective factors despite the challenges they face as sexual and racial/ethnic minorities. Aspects of their dual, intersecting identities that may create adversity (strong ties to racial/ethnic communities, religious or spiritual faith) also tend to be sources of strength. Table 2 reviews racial centrality, resilience, religiosity and spirituality, and social support and how these factors can be protective in the lives of YBGBM. These factors can sometimes buffer the negative effect of existing within multiple marginalized identities. For example, prior work suggests that for some YBGBM a positive societal view of Black men was associated with decreased sexual risk behavior [89].

Clinical Considerations

YBGBM are a unique population existing at the intersection of four often medically underserved groups – male, young, Black, and sexual minority. Additionally, many often are from economically depressed settings. Each of these groups has historically had poor relationships with health care settings. Males are less likely to access primary care, health promotion or preventive services compared to female patients [94]. Youth have similar barriers; a normal component of adolescent development is the illusion of invulnerability and invincibility; however this illusion has been correlated with risk behaviors and poor engagement in health care and health promotion [95]. Black individuals have characteristically had low levels of health care utilization as a result of historical and contemporary barriers to care including financial and structural access barriers, medical mistrust, and history of unequal and maltreatment [96]. Sexual minorities have similarly had

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barriers to care resulting from poor cultural competency and low provider knowledge of the health care needs of gay, lesbian, bisexual, and transgender individuals [97]. While disparities in HIV may have increased access to HIV testing and other preventive health services in underserved areas, those in economically depressed areas have significant barriers to care including cost and insurance [98], transportation [99], and competing socioeconomic needs (e.g. employment, food, housing).

YBGBM at the intersection of all of these social categories face all of these challenges. Moreover, these challenges are not simply additive, rather, they are interdependent and mutually reinforcing [5, 6]. Very few studies have explored the health care experiences of YBGBM. While some have focused on primary care or preventive health services the majority focus on engagement and retention of HIV-infected youth. Reflecting the multiple challenges above, these studies have found the following factors were positively associated with treatment engagement, retention and health care utilization: feeling respected in clinical settings, receipt of social services ethnic identity affirmation, and employment [79], while negative self-image, medical mistrust, racial and sexual orientation stigma from providers, and stigma disclosing same-sex behavior were negatively associated [79]. In a qualitative study, adult Black MSM described experiences of racial and sexual discrimination in medical settings that compounded similar experiences in other aspects of their lives and negatively impacted their medical utilization, HIV testing, communication with providers and medication/treatment adherence [100].

Summary and Recommendations

We have used an intersectionality framework to describe how occupying multiple stigmatized social identities can create unique challenges for YBGBM as an example. Such intersection can predispose YBGBM to risk and poor health outcomes. Young Black gay, bisexual and other men who have sex with men must achieve the tasks of adolescence at the intersection of multiple social categories such as race, socioeconomic status, gender (and gender expression), religion and sexuality. This experience is compounded by multiple threats to their health and well-being from their social environment at the interpersonal, intermediate structural, and macro-structural levels. These threats reflect the social inequities this group is disproportionately burdened with as members of multiple oppressed and marginalized groups.

When caring for YBGBM, it is important bear in mind the importance of culture, family and religion in identity development and to assess the following: 1) the social context in which the adolescent lives in (in order to assess contextual factors that may predispose some YBGBM to risk); 2) a youth's identities, including racial, sexual and cultural group identity; 3) to whom youth have disclosed their sexual orientation; and 4) whether they must exist in certain environments (hypermasculine, religious, etc) that prohibit them from disclosing their sexual orientation to others.

Clinicians should also keep in mind that promoting factors (e.g., racial segregation, homonegativity and stigma) could modify exposure to risk to increase poor outcomes, while protective factors (e.g., resilience, race-centrality and social support) may help to protect

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YBGBM from risk. While this article focused primarily on YBGBM, the intersectionality framework discussed here is also an important lens for other LGBT youth of color and other racial/ethnic groups who may have to cope with specific sociocultural factors related to sexual orientation, gender expression or gender identity that influence health outcomes. Clinicians should be aware of the unique challenges that impact sexual and gender minority groups that occupy multiple marginalized circles in order to adequately assess, develop programs and cultivate skills in YBGBM that promote protective factors and block the impact of negative promoting factors.

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Key Points

- Young Black Gay and Bisexual Men (YBGBM) in particular experience multiple inequities compared to their majority peers by virtue of their membership in multiple oppressed and marginalized groups.
- Intersectionality is a theoretical framework that suggests that multiple social identities – e.g. race, ethnicity, gender, and sexual orientation – intersect at the individual or micro level of experience and reflects larger social-structural inequities experienced on the macro level.
- Intersecting identities predispose YBGBM to adverse health outcomes and health inequality, which are further modified by promoting and protective factors.

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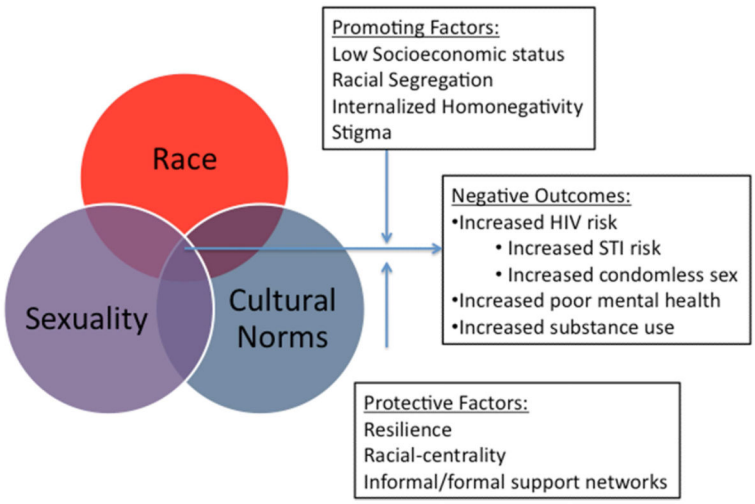

Figure 1.
Key intersecting identities of Young Black gay and bisexual men

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Table 1

Promoting factors affecting adverse health outcomes among YBGBM

Domain	Key Points
Socioeconomic Status and the Structural, Social and Built Environment	- Racial disparities in health can be explained by differences in socio-economic status and low socioeconomic status has been associated with health-related behaviors and poor health outcomes [50] [51] Structural, social and built environment where people live -- also explains many of these disparities [52]. - HIV and other poor outcomes are often clustered in areas stricken by poverty, crime, high density of alcohol outlets, poor performing schools, food deserts, vacant houses, and other markers of underinvestment in infrastructure and social services [53]. - These areas are often characterized by socio-economic inequity, which can lead to negative health outcomes through poor social cohesion, low collective efficacy, and physical and social disorder [54]. - Several studies have demonstrated an association between the social and environmental context of disadvantaged neighborhoods and sexual risk behavior or sexual outcomes among heterosexual adolescents and emerging adults [54]. Far fewer studies of this sort have been done among YBMSM, but there is evidence of similar associations. In a study of 1,289 YBMSM (18-29), socioeconomic distress (as measured by < high school degree or GED, < fulltime employment, annual income < $20,000, in the past year borrowing money to meet basic needs or running out of money at least once, ever being incarcerated, and ever being homeless) was associated with condomless anal intercourse (CAI), a significant risk factor for HIV [59]. A similar study of 328 Detroit YMSM (age 18-29), demonstrated those with income below the poverty line were less likely to have ever been tested for HIV and more likely to report CAI with a serodiscordant partner. In the same study, YMSM living in neighborhoods with greater socioeconomic disadvantage were more likely to have had an HIV test and less likely to report CAI with serodiscordant partners, a finding authors postulate may be due to targeted HIV control efforts to address HIV disparities in underserved areas[60].
Racial Segregation of Sexual Networks and HIV Risk	- New HIV infections among YBMSM (aged 13-24) continue to outpace other racial/ethnic MSM subgroups in the US [4],despite equivalent or lower rates of individual HIV risk behavior [61]. - Racial/ethnic segregation -- particularly in poor, urban, inner city environments -- has left Black and other racial/ethnic minorities disproportionately affected by both low SES and social and built environments that negatively impact health [55]. Public health surveillance data and several studies have demonstrated that Black MSM are more likely to live in neighborhoods with lower income [56, 57] and higher HIV prevalence [56, 58] and are more likely to have lower individual SES compared to White MSM [56]. - Evidence suggests that HIV disparities affecting YBMSM are perpetuated by differences in their sexual networks including greater race concordance and age discordance between sex partners, higher sexual density(i.e. extent to which members are having sex with each other), and greater likelihood of residence in neighborhoods with high HIV prevalence in YBMSM sexual networks[58, 62-65]. - Another notable difference is the racial segregation of sexual networks. Preference for Black partners has been described in qualitative studies of young and adult Black MSM [17, 18, 66] and likely reflects salience of Black identity and desire for shared experiences [67, 68]. However, there is also evidence of marginalization of Blacks in sexual minority communities that contributes to the racial homogeneity of the sexual networks of Black MSM. [69, 70].
Internalized Homo-Negativity (IH)	- Internalized homo-negativity/homophobia (IH) is an unconscious process where negative societal messages about lesbian, gay, bisexual people become internalized by lesbian, gay and bisexual persons [38]. - The impact of IH on health outcomes has been unclear, but strongest associations have been seen with mental health outcomes, where higher IH predicts greater internalizing mental health problems (e.g. depression and anxiety) [71]. There have also been positive associations reported between IH and guilt, shame, and low self-esteem and evidence that IH also predicts poor sexual identity development and non-disclosure of sexual identity [72]. - Youth specific studies have been limited, but existing work has demonstrated links between IH and unsafe sexual behaviors, substance use, and non-disclosure of sexual orientation among sexual minority youth [71, 72]. - Internalized homophobia has also been shown to vary by race and class with greater IH associated with Black race, lower education, poverty, homelessness, and history of incarceration [73]. Qualitative studies of YBGBM and adult Black MSM have consistently described internalization of homo-negative messages among study participants, the negative impact on psychological well-being, and the mechanism by which these ill effects can lead to increased HIV risk [30, 74].

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Domain	Key Points
Stigma	- Black gay and bisexual men experience stigma and discrimination in the form of isolation and detachment from both the Black and gay community [75, 76]. - The personal experience of stigma, homophobia and discrimination related to one's race and sexual orientation has been directly related sexual risk behavior including condom non-use [59], poorer mental health outcomes, including low self-esteem, increased depression, anxiety, suicidal ideation and suicide attempts [38, 77], and maladaptive coping strategies including substance abuse and engaging in fewer health-seeking behaviors [78]. - HIV related stigma additionally impacts care for HIV-infected and at-risk YBGBM and has been associated with a delay in care seeking after HIV diagnosis and non-adherence to HIV medical appointments [79] and may be a barrier to HIV and other sexual health promotion screening services [80]. - Minority stress theory suggest that it is the additive effect of socially-based membership in marginalized groups that further magnifies the type of social stress that is the result of one's environment [81].
Limited Social Connections	- YBGBM are less likely, compared to White peers, to benefit from connectedness to sexual minority communities. The experience of racism in predominantly White sexual minority communities has been cited as a deterrent to seeking connectedness or support from these communities [69, 82]. - Black gay, bisexual and other men who have sex with men often describe social isolation and lack of social support from Black communities and, in qualitative studies, have consistently reported the absence of organized communities and opportunities to connect with and support one another, citing homophobia and secrecy around same-sex behaviors as contributing factors [74]. - Instead opportunities for interpersonal and peer social interaction, particularly for young men, have been limited to pornography[83], sexual venues and social media outlets [7, 84]. This social isolation and lack of social support can have deleterious effects on identity development, self-mastery and self-esteem [85], lead to internalized homonegativity and identity concealment [30] and contribute to sexual and other risk behaviors [86].

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Table 2

Protective factors affecting the health of YBGBM

Domain	Key Points for Primary Care Providers
Race Centrality	- Racial-centrality, the degree to which racial identity is central to one's overall identity, has been consistently identified as a protective factor against negative health-related outcomes in African American/Black adolescents [88]. - Prior work suggests for some young Black gay and bisexual men high racial centrality and racial public regard (beliefs about how society views Black people) was associated with decreased sexual risk behavior including condomless anal intercourse [89].
Resilience	- YBGBM may be more resilient than their heterosexual and nonminority peers because they occupy two identities that have been historically stigmatized in American society [5]. - Studies suggest young Black gay/bisexual and other MSM have substantial resilience operationalized through their inner strength, positive social relationships, altruism and the ability to create communities and sources of support [74]. - Researchers have suggested that some protective resilience occurs as a result of the high returns and connectedness of being a part of a racial/ethnic identity and may be in excess, and thus, protective of the returns experienced as part of sexual minority communities [16].
Religiosity and Spirituality	- There is evidence that religiosity and spirituality can also be protective among YBGBM. Prior work of racially diverse YBMSM suggests faithfulness and frequent formal religious attendance was associated with less condomless anal intercourse with male partners [90]. - Other work suggests YBGBM experience psychological benefit from church attendance and religious affiliation in spite of any homo-negative messages present in this social environment, and [48]. Even among those who have left traditional church affiliations, spirituality remains a salient component of their self-concept and source of strength and resilience [49].
Social Support	- Parental and family support provides resources to cope with social adversity and predicts positive well-being and health outcomes [14] including reduced depression and increased self-esteem [91] for racial and sexual minority youths. - For youth rejected by their families, seeking support from sexual minority communities can be an important and effective coping strategy. Community connectedness appears to be protective against homo-negativity and homophobia and has been associated with psychological well-being in YBGBM [92]. - In some urban settings there are community based organizations developed by and for Black sexual minority communities (e.g. Gay Men of African Descent in New York, NY) [16], and several studies have described informal communities and gay 'family' structures in and outside of the House and Ball Culture [93] where sexual minority youth of color are provided social support from older peers that act as parental figures when parental support is absent.